RHEUMATIC FEVER: A STUDY OF THE SERVICES FOR CHILDREN WITH RHEUMATIC FEVER AND RHEUMATIC HEART DISEASE AS OFFERED BY FOUR STATE PROGRAMS AND THE ROLE OF THE MEDICAL SOCIAL WORKER IN THESE PROGRAMS

A THESIS

SUBMITTED TO THE FACULTY OF ATLANTA UNIVERSITY SCHOOL OF SOCIAL WORK IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SOCIAL WORK

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ATLANTA, GEORGIA

JUNE 1949

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CHAPTER I

INTRODUCTION

Rheumatic fever has become increasingly more important since World War I. This has been true because as deaths from other so called childhood diseases have decreased, deaths from rheumatic fever have increased. This may be due to the fact that diagnosis of the disease is now more accurate than previously. It is now recognized that rheumatic fever kills more school-age children in the United States than any other disease.[1] This has probably been the case because science has found methods of isolating the causative factors in other previously dangerous childhood diseases, devised cures or ways of arresting these diseases. In many cases it has been possible to prevent them through immunization. This is not true of rheumatic fever. Such a lack is, of course, significant. However, this matter will be discussed more fully in the next chapter of this study.

The fact that more children die because of this disease or are crippled by it every year has caused much concern to both the medical profession and to the social worker. Dr. George Wolff has written a most informative booklet published by Federal Security Agency entitled "Childhood Mortality from

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[1]United States Department of Labor, Children's Bureau, Facts About Rheumatic Fever, Publication 297, September, 1945, p. 2.

Rheumatic fever and Heart Diseases."

He gathered statistics about rheumatic fever and studied them in relation to several significant factors such as: age, race, sex and geographic location. He found that the age range in which one is most likely to find rheumatic fever infection is from five years through nineteen. Regarding age trends, Dr. Wolff states:

> With increasing age, mortality from acute rheumatic fever and heart diseases (all forms) increases markedly during childhood. Among boys in the United States during 1939-1941, average annual mortality due to these causes was 8.2 per 100,000 in the 5-9 year age group, 11.6 in the age group 10-14, and 14.8 in the age group 15-19. Correspondingly for girls, the rates for these causes jointly increase from 8.6 per 100,000 among 5-9 year-olds to 12-5 at 10-14 years of age and 13.9 for girls in the 15-19 year age group.[1]

After Dr. Wolff applied his findings to racial groups (white and non-white), he further classified them by sex. He found that for all of the age groups the non-white female tended to die more frequently from rheumatic fever than did the non-white male. He found this to be true for the white female also with the exception of the 15-19 year age group. Here, she was excelled by the male only for chronic rheumatic heart diseases. Dr. Wolff gives as the possible cause for the high percentage of mortality in the non-white group the fact that usually this group of persons must live in a more unfavorable social

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[1]George Wolff, M. D., Childhood Mortality from Rheumatic Fever and Heart Diseases, Children's Bureau Publication 322, 1948, p. 10.

environment.[1]

In reporting his findings on the geographic distribution of rheumatic fever, Dr. Wolff says that the average crude rate for the United States is 11.7 per 100,000.[2] He found, as many others have who studied the disease that

> ....the death rates for acute rheumatic fever plus heart diseases are below average in the South while in the Northeast, especially in the Middle Atlantic division, they are significantly above average. In the Pacific division the death rates are as low as in the South and significantly below the country's average, while in the Mountain division they are exceptionally high for the white children in all age groups.[3]

The length of time required for treatment of rheumatic fever, creates many social and emotional problems for the patient and his family, such as do not ordinarily arise in illness of short duration. The diagnosis of the disease causes anxiety in both the patient and the family, because it may mean a crippling heart damage. This in itself is frightening.

The family needs to talk freely at such a time, with some one who has time and understanding, to listen to the manifold questions they may raise, and to aid in allaying some of their fears. Readjustment may be required of all members of the patient's family, and this may cause emotional imbalance on the part of the whole family. There may be worry over the cost of medical care which may disturb the family equilibrium.

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[1] Ibid., p. 11.

[2] Ibid., p. 25.

[3] Ibid., p. 24.

The sick child may develop habits of dependency and regression, and parental responses may be either of rejection or over protection. The child may possibly react to his disease with a feeling of inadequacy and insecurity, which makes him fearful of returning to normal activities, or to the limited physical activities imposed by his illness.

With any one, or all of these problems, the patient and his family may need the help, not only of the physician, but the social worker. Her training, experience and understanding of the meaning of illness; and the emotional factors which may color any long-time disability, fit her to aid in the solution of these difficulties.

Statement of the Problem

This is a study of the services for children with rheumatic fever and rheumatic heart disease, as offered by four state programs. Special attention is given to the role of the social worker.

Purpose of the Study

The purpose of this thesis is to point out the medical, emotional and social factors involved in rheumatic fever and rheumatic heart disease; and to evaluate the services offered to combat this disease in four sections of the United States (representing Eastern, Western, Middle Western and Southern areas).

Scope of the Study

This study will cover the services to patients with rheumatic fever and rheumatic heart disease in four states; New York, California, Michigan, and South Carolina; the latter being the only state offering complete coverage.

Method of Procedure

This is a library study, and the factual and statistical information was obtained from an examination of state reports. A selected bibliography was also used.

CHAPTER II

SOME FACTS ABOUT RHEUMATIC FEVER AND THE ROLE OF THE SOCIAL WORKER IN TREATMENT

Definition

Rheumatic fever is a chronic, infectious, and often recurring childhood disease; however, rare cases have occured in adults. In its acute stage it may be painful, causing swelling and redness of the joints of the arms and legs. However, its attacks may be of such a mild nature that they pass unnoticed. All too often, the pain of rheumatic fever is thought to be that of "growing pains;" paradoxically, joint pains do not always mean rheumatic fever.

Etiology

Science has not yet discovered the cause of rheumatic fever. It is now known from research that about ninety percent of the cases of rheumatic fever have been preceded by a hemolytic streptococcic infection. This does not offer conclusive proof for the etiology of the disease because there have been patients with a known infection of this type who have not developed rheumatic fever. Then, too, some have been found who are very definitely rheumatic fever patients and have had no known streptococcic infection.[1]

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[1]George C. Griffith, "Epidemiology of Rheumatic Fever," American Journal Public Health, XXXVIII (May, 1948), 682.

Symptoms

The symptoms of rheumatic fever also tend to make the disease one that is hard to diagnose for they may be the symptoms of almost any of the so-called childhood diseases. Some of the characteristics which a rheumatic fever patient may exhibit are: loss of appetite and weight, general pallor, lack of interest in activities about which he was formerly enthusiastic, and pain or swelling in first one joint and then another, accompanied by high fever.[1]

Another form of rheumatic fever is St. Vitus' dance or chorea. This is usually manifested by awkward and jerky movements of the child's face, arms, and legs especially when he tries to feed himself or to pick up objects. Frequent and unexplained crying may also suggest the possibility of chorea.[2]

Diagnosis

Of course, the only person who is equipped and trained to diagnose the presence of rheumatic fever is the doctor. Nevertheless, the parents and other interested persons should be cognizant of the symptoms of this disease in order that they may be better able to tell when to take the child to the physician. Frequently, it is necessary for the doctor to make

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[1]Herbert Yahraes, Rheumatic Fever, Public Affairs Committee Inc., Public Affairs Phamphlet 126, 1947, p. 2.

[2]United States Department of Labor, Children's Bureau, Facts About Rheumatic Fever, Publication 297, September, 1945, p. 2.

several tests before he can state with any certainty whether the disease is present or absent. Some of the most common of these test are the blood sedimentation rate test, the electrocardiogram, and fluoroscopic (or x-ray) examinations. Even with these aids it is often necessary for the general practitioner to call in a heart specialist or pediatrician.

Treatment

Although little is known about the disease, a treatment has been devised that has been found to be satisfactory if followed carefully. The chief difficulty the patients and often the parents of the children find, is that it is necessary for the affected child to spend long periods of time in bed. Often, the children feel quite well and normal after the acute stage of the disease has passed. Naturally, the youngsters wish to be up and about so that they may carry on their daily routine of school and play. Quite a bit of hostility can be built up between the parent and the child who does not understand why he must stay in bed. Here the medical social worker can play an important role in interpreting, both to the parent and to the child, why rest is necessary and the importance of otherwise following the doctor's orders.[1]

Role of Medical Social Worker in Treatment

Not only must the social worker help the child and the

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[1]Ethel Cohen, "What Rheumatic Fever May Mean to a Child," The Child (April, 1947), p. 1.

parent to understand why this disease necessitates long periods of inactivity and rest, but often she must also explain why the youngster must spend a long time in the hospital. One of the greatest dangers involved in rheumatic fever is the possibility of the patient being infected by other diseases.[1] If the child remains in the hospital until the doctors are certain the danger period has passed, they may possibly prevent further complications.

Since these patients must be separated from their parents, siblings, and natural environment for a long time, many problems of adjustment necessarily arise. The social worker can assist in the solution of these. The length of time necessary for the arresting of rheumatic fever causes the child to lose much time out of school. He does not wish to be left behind by his classmates, nor does he want his education stopped at this point. Because rheumatic fever most frequently attacks persons within the school age group, many of the victims of this disease will have this problem. The social worker can explore the community's resources to see what services are available to the children. During the quiescent period of the disease, many of the patients will find occupational therapy useful. Some of the older patients will probably need vocational guidance following recovery.

Rheumatic fever is a long-time illness; therefore, the

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[1] Ibid., p. 3.

medical social worker can often be of help to the family in working out some arrangements regarding the financial aspects of the illness. Although this disease is no respecter of persons, it has been found most frequently among those people who have poor living conditions, poor nutrition, improper clothing, and generally unhealthful surroundings.[1] Children in families of low income, apparently, are most often attacked and are unable to pay for the long-time care which a rheumatic fever patient requires. For this reason, most of the states have worked out some plan whereby those within its borders who are rheumatic fever victims can receive medical care. In many of these states, under the Crippled Children's program, the Federal government matches state money for this purpose.[2]

Not only may these persons be unable to pay for good medical attention, but their homes may often be inadequate for the type of convalescent care the doctor recommends. When this is the case, the medical social worker can assist in arranging convalescent or foster home care for the child. She can help the patient and the parent work through their feelings regarding separation. She will also need to work closely with the foster

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[1]Ethel Cohen, "Medical Social Problems of Rheumatic Children." As presented at the Fourth Session of the Maternal and Child Health Section of the 69th Annual Meeting of the American Public Health Association, Detroit, October 11, 1940, p. 1.

[2]Betty Huse, M. D., "Care of Children with Heart Disease in the Crippled Children's Program under the Social Security Act," American Journal of Public Health, XXXI:8 (August, 1941) p. 809.

parents, to interpret to them the needs of the child so that they will have an understanding of what his illness means to him as well as a knowledge of the doctor's recommendations.[1]

All of the problems of the illness are not solved when the patient is safely out of the home and secure and happy in either hospital or foster home. There is the danger that the family may become accustomed to the patients' absence, and his return may create other problems. Since many of these families are in the marginal income bracket, they will have made many sacrifices for the ill person, and there may be strong feelings about this. Siblings frequently dislike seeing one of their number receive favors or privileges denied them simply because the other is sick.

Even after recovery, the patient may still have difficulty adjusting to his environment. He himself may be reluctant to give up the favors his illness gets for him; hence, he may wish to remain ill. Parents, thinking they are doing what is best for the child, may unconsciously encourage this in their own attitudes toward the child and his illness.

It is in the area of family relationships and attitudes, that an alert and understanding social worker can be very helpful. Those in the home who have the major responsibility for child's care, should be encouraged to do nothing which will

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[1]Virginia B. Ebert, "Case Work Services to Children with Rheumatic Heart Disease," The Family (March, 1941), p. 7.

foster his invalidism. Within his physical limits, as determined by the physician, he should be assisted to a life as normal as is possible.[1]

The medical social worker can be very helpful in giving necessary interpretation regarding the importance of after care. As has been previously pointed out, rheumatic fever often necessitates prolonged hospitalization followed by many months of convalescent care. Periodic clinical examinations are the usual procedure recommended by pediatricians. All the care in the hospital and the convalescent or foster home can be wasted if the child does not get these regular clinical examinations.[2]

The social worker may find that it is her task to arrange for transportation so that this care may be available; as it is often particularly difficult for parents to arrange for this type of service in rural areas.[3]

Not only does the medical social worker function as a member of the medical team in the clinic or hospital, but she is often also the liason person between medical institution, home, school, and community.

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[1] Ibid., p. 10.

[2] Ethel Cohen, "What Rheumatic Fever May Mean to a Child," The Child (April, 1947), p. 3.

[3] Ethel Cohen, "Medical-Social Problems of Rheumatic Children," American Journal of Public Health, XXXI:8 (August, 1941), p. 819.

CHAPTER III

NEW YORK STATE PROGRAM FOR THE CARE OF CHILDREN WITH RHEUMATIC FEVER

The rheumatic fever program in the state of New York is administered by the New York State Department of Health under the Bureau of Maternal and Child Health. The purpose of the program, as stated in their March, 1949, manual, is as follows:

> ....to find children who have rheumatic fever, to remove the label of rheumatic fever from children falsely diagnosed, to promote the development and intergration of services and facilities needed in the community, and insure that patients receive adequate and continuing care, methods for finding them, standards and precedures for insuring the proper utilization of these services.[1]

The rheumatic fever program in New York is an intergrated array of services, public and private as well as state and local, but the program is not wholly state-wide in coverage. Therefore, in planning, all of these community agencies were considered for the part they could best play in aiding the treatment process.

Description of Services

A patient is eligible for services under the New York rheumatic fever program if he is under twenty-one years of age and if he falls within any of the following categories:

1. Children acutely ill with rheumatic fever.
2. Children convalescing from acute rheumatic fever or

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[1]New York State Department of Health, Bureau of Maternal and Child Health, Guide for Local Rheumatic Fever Programs, Albany, March, 1949, p. 3.

having low-grade rheumatic activity.
3. Children recovered from an attack of acute rheumatic fever with or without demonstrable rheumatic heart disease.
4. Children with rheumatic heart disease with a preceding history of acute rheumatic fever.
5. Children with illnesses in which the diagnosis of rheumatic fever must be considered.
    a. Acutely ill bed patients with symptoms suggestive of rheumatic fever.
    b. Ambulatory patients with symptoms suggestive of rheumatic activity or inactive rheumatic heart disease.
6. Children with suspected or diagnosed congenital heart disease.[1]

Direct services.--General medical service should be provided through the family physician. He is the key person in finding unknown cases of rheumatic fever because he has seen the patient during the streptococcic infection. Other services needed for the rheumatic fever patient are:

1. Consultation services which would include laboratory, x-ray, and electrocardiographic studies.
2. Medical services for bed patients at home.
3. Social services.
4. Nursing.
5. Institutional care.[2]

Provisions are made under the program for prolonged aftercare when indicated, either in convalescent or foster homes. These follow-up services are available in New York during all stages of the illness, to insure continuity in treatment. Provision is also made for regular, periodic examinations, either by the child's family physician or in out-patient departments

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[1] Ibid., p. 3.

[2] Ibid., pp. 1-6.

of clinics and hospitals.[1]

The public health nurse and the medical social worker collaborate in rendering direct services, each in his particular area, to insure adequacy in follow-up care. It is interesting to note the role played in the program of vocational guidance in the rehabilitation of these patients. This phase is given emphasis as early in the care of the patient as his physical condition and psychological readiness warrants.[2]

Supporting services.--The New York program puts a great deal of stress on certain services which support the program and give it impetus. Notable among these services are their health education activities. This is designed as a preventive measure and information is distributed to the general public about this disease and its meaning as a public health problem.

Available facilities for diagnosis and treatment are publicized to bring about an awareness of the implications of the disease as well as to acquaint the public with the medical, social, and emotional needs of the child who is a victim of this disease. Special emphasis is placed upon the value and importance of early diagnosis and treatment of any child who does not appear to have normal health.[3]

The medical authorities, in promoting this educational

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[1] Ibid., p. 7.

[2] Ibid.

[3] Ibid., p. 8.

program, exercise extreme care to avoid creating needless anxiety by calling undue attention to physical symptoms. The main purpose of this supporting service is that of prevention.[1]

Another service rendered by this program is one in which professional education receives emphasis. The purpose of this is to promote the clinical knowledge and medical understanding of rheumatic fever among physicians. They, therefore, foster post-graduate education not only for doctors but for nurses and other professional personnel who may be working in medical institutions with rheumatic fever patients. The various needs of the patient are discussed and studied, as well as the facilities which are needed in the adequate care of these individuals. Often, lectures and demonstrations are given for the benefit of the groups who work with the patient.[2]

In discussing rheumatic fever, the role of the medical social worker and that of the nurse is most interesting. Many are vague as to the difference in the contribution offered by each in caring for these patients. In the New York program, the local health departments may provide public health nursing services which actually include bed-side nursing. The nurse may make home visits to interpret medical recommendations, to get other children in the family examined (since this disease may tend to "run in families"), but she leaves to the medical social worker the realms in which social and emotional problems

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[1] Ibid., p. 8.

[2] Ibid.

are paramount. They work together, usually conferring frequently and agreeing upon areas of responsibility. They, of course, constitute members of a team of which the head is the physician, and they work under his leadership and upon his recommendations. They complement each other, recognizing that they are treating the whole child and are endeavoring to bring about physical, social, and emotional well-being.

The health department provides financial assistance defraying the cost of medical consultation, and it is this agency which is also responsible for whatever expenditures are necessary for public and professional education. They are also responsible for the provision of school health services. These include medical examinations and health supervision of the child all through his school years. Also, financial assistance is provided by the health department for hospital and convalescent care. This is one of the states which also provides, through its public health department, for the services of a medical social worker as well as those of a nutritionist.[1]

The state department of health makes provisions in the local programs for consultation services in the following fields: medical, nursing, social work, public health education, and nutrition. The state also gives financial assistance for certain phases of local programs and allocates special grants for demonstration projects. The state department is also

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[1]Ibid., p. 13.

responsible for setting standards for certain parts of the program. They also aid in the training of professional personnel in the public health field. They are responsible for integrating and coordinating local rheumatic fever programs with those on a regional and state-wide basis. They are responsible for developing health educational materials.[1]

School authorities may foster the health education of the school child as a part of their regular classroom instruction. They may offer the following services: medical examination, procedures to screen out suspected cases, and in-service training for teachers and staff members to encourage better understanding of the physical, social, and emotional needs of the child with rheumatic fever. They may provide special schools or special classes for rheumatic fever children. It is the schools which provide vocational guidance and placement service which are under the auspices of the state educational department.[2]

In the coordination of services to the rheumatic fever child the Department of Public Welfare plays an important part. Among the services which this agency may provide is financial assistance for medical and any other services for which clients of the agency are eligible. The department also gives help in the solution of social problems involving the adjustment of

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[1] Ibid., p. 14.

[2] Ibid., p. 15.

either the patient or his family to this disease. This may mean environmental manipulation and eliminating over-crowding in a poor and inadequate home. The Department of Public Welfare may provide foster home care for patients whose homes are unsuitable and for whom convalescent care in an institution is not available. The department also gives assistance to the state department of health in the maintenance of standards in hospitals, special institutions for convalescent service, and foster homes.[1]

Voluntary nursing agencies such as Visiting Nurse Association may provide bed-side attention in the home. New York state is fortunate in that many of their Visiting Nurse Associations actually provide complete family care, with health guidance, while some of the other associations in the state may assist selected clinics by supplying nurses.

Family agencies as well as other case work organizations lend maximum support to the rheumatic fever program. Sometimes, these agencies may supervise and give financial aid to facilitate foster home care for certain patients.[2]

Fraternal organizations such as the Shriners, Elks, and certain service clubs give definite and constructive aid to this program.[3]

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[1] Ibid., p. 16.

[2] Ibid.

[3] Ibid., p. 17.

Standards for Services

It is impossible in this limited study to go as thoroughly into the matter of standards as one would desire. There are, however, certain minimum standards for clinics which provide services for children with rheumatic fever or rheumatic heart disease:

1. Every clinic which offers diagnostic services to these patients should have at least one qualified pediatrician or internist, in attendance and responsible for medical supervision during the clinic session.
2. There should be provision for such services as medical history and physical examinations on each patient, laboratory examination and tests for urinalysis, complete blood counts, sedimentation rates, fluoroscopy and x-rays, electrocardiograph. Also provision for adequate nursing and social services. Provision for the keeping of adequate records. Provision for adequate follow-up service.[1]

Special institutions should be supervised by a qualified pediatrician or internist, and there should be adequate medical residential staff, including nursing staff. Also, there must be provision for: record keeping, adequate daytime residence, education, recreation, occupational therapy, social work, and consultant service. This last is very important; the institution should not permit any patient who has an infection other than rheumatic fever to be admitted to the unit which houses rheumatic fever patients.[2]

For hospital care, minimum standards are:

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[1] Ibid., p. 19.

[2] Ibid., p. 20.

> That the medical institution conform with the standards laid down by the standard setting body known as the American College of Surgeons for General Hospitals. This means that there would be provisions for adequate medical, nursing, medical social, nutritional and laboratory facilities. Here again, provision must be made for adequate follow-up care. In the hospital also there should be provisions for education, recreation and occupational therapy. It goes without saying, of course, that there should be protection against fire hazards.[1]

Of course, in urban communities in the state there will probably be adequate hospital facilities for the child who has an acute attack of rheumatic fever. However, even in an urban area, when the period of convalescence arrives, most communities are unprepared to offer complete and adequate facilities for convalescence. Then it is, that the child must be made as comfortable as it is possible in his own home, if it happens to be one the physical surroundings of which are conducive to the rest and quiet and order which is required.

In rural communities, the child suffering with rheumatic fever often spends his whole period of illness in his home, because of lack of facilities elsewhere. During this period, the victim of rheumatic fever should have the careful supervision of a good physician and, if possible, a nurse. In the home, educational provisions can also be made; the medical social worker is usually most helpful in securing someone who can tutor the child, read to him, play quiet games with him, and involve him in some type of occupational therapy. All along

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[1] Ibid., p. 21.

the road, from the time that rheumatic fever is diagnosed and treatment is begun until convalescence is experienced, the medical social worker contributes to the ongoing treatment and ultimate welfare of the child and his family.

CHAPTER IV

SOUTH CAROLINA STATE PROGRAM FOR THE CARE OF CHILDREN WITH RHEUMATIC FEVER

Description of Services

South Carolina is one of the few states that has over-all coverage for the care of patients with rheumatic fever. Their program is administered through the State Crippled Children's Division of the State Board of Health. It is to this division that the writer is indebted for much of the factual and statistical information in this chapter.[1]

The rheumatic fever program is divided into three districts. The Charleston District has its headquarters at the State Medical College, Charleston, South Carolina; the counties included in this district are: Barnwell, Allendale, Hampton, Jasper, Baufort, Bamberg, Georgetown, Colleton, Orangeburg, Horry, Dorchester, Charleston, Claredon, Berkely, and Williamsburg.[2] The Columbia District meets at the Columbia Hospital, Columbia, South Carolina; it covers the following counties: Edfefield, Aiken, Saluda, Lexington, Newberry, Fairfield, Richland, Lancaster, Kershaw, Lee, Chesterfield, Darlington, Florence, Marion, Marlboro, Dillon, Sumter, and Calhoun. The Greenville District meets at the Greenville General Hospital, Greenville,

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[1]South Carolina State Board of Health, Division of Crippled Children, Policies and Procedures (Columbia, South Carolina, March, 1948).

[2]Ibid., p. 43.

South Carolina; Oconee, Anderson, Abbeville, McCormick, Pickens, Greenwood, Greenville, Laurens, Chester, Spartanburg, Union, Cherokee, and York counties are in this geographic district.[1]

The South Carolina program for rheumatic fever patients is set up primarily to help those persons within the state who are indigent or medically needy. All patients are encouraged to make whatever contribution they can toward their medical care. The medical social worker helps to evaluate economic status in order that a realistic decision can be made. Those persons who feel they can contribute to the medical costs are classified as part-pay patients. Usually they are unable to pay more than ten dollars for complete diagnostic services. The situation is reevaluated if long hospitalization or convalescent care is indicated.[2]

Private patients are accepted only if diagnostic services are not available or if the attending physician requests in writing that diagnosis be made. Little service is done for these patients, as they are not eligible for services under the program. The minimum clinic fee for these persons is ten dollars, with the understanding that there may be other charges for x-ray or other laboratory tests.[3]

South Carolina has one convalescent home at Florence, South Carolina. It is a fifty-bed institution, with twenty-five beds reserved for the use of Negro patients. It is owned by the

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[1] Ibid., p. 43.

[2] Ibid., p. 44.

[3] Ibid.

state and operated by the Division for Crippled Children of the State Board of Health.[1] Admission for a rheumatic fever patient must be preceded by the request and recommendation of a recognized pediatrician. The medical social consultant visits the convalescent home at least once a month, to discuss with the medical team there the social situation of the new cases admitted during the month, in order to make plans anticipating of discharge and relative to any other medical social problems that have arisen with the patients who have been there for some time.[1]

In this state, there are four foster homes providing convalescent services. Two are for the use of Negro patients,one in Spartanburg and the other in Charleston. The two homes for whites are in Greenville and Charleston. The State Department of Welfare has an agreement with the Division of Crippled Children whereby they make the initial investigatory visit for the licensing of these homes. They also make a follow-up, re-evaluating visit a year later. The district medical social worker also visits these homes to handle those cases in which problems have arisen because of illness and it is felt that help can be obtained through the use of social case work.[2]

Duties of Medical Social Consultant

In this program, the medical social worker operates on

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[1]Manual, op. cit., p. 36.

[2]Ibid., p. 14.

two levels, that of a medical social consultant and as district medical social worker. According to the State Manual, the consultant's duties are outlined as follows:

A. To give consultation service concerning the medical social problems of crippled children to local medical-social, child welfare and other social workers, and to public health nurses and other health and medical personnel.

B. To confer with individuals and groups (non-professional) concerning unmet social and economic needs, such as dietary, educational, recreational and housing.

C. To conduct social interviews on special cases at clinics or elsewhere in order to discover any social problems effecting medical treatment.

D. To assume responsibility for planning to meet social problems connected with admission to, care in, and discharge from, hospitals or convalescent home.

E. To utilize and develop community resources for care of crippled children.

F. To cooperate with rehabilitation services by selecting and referring children for vocational rehabilitation services.

G. To cooperate with child welfare workers in foster home placement and supervision of crippled children.

H. To participate in case conferences and in staff development programs.

I. To select and prepare case material for educational purposes.

J. To assist in studies and surveys of the provisions for meeting the social needs of the crippled child.[1]

Duties of Medical Social Worker

The medical social worker will find that her job

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[1] Ibid., p. 36.

includes:

A. Assists in giving consultant service relating to the medical social welfare of crippled children.

B. Aids in assembling medical and social information for letters to patient's parents and assists in interpreting to parents, county officials, and interested agencies the medical treatment of children under care.

C. Conducts interviews with parents or guardians of patients attending clinics when necessary.

D. Makes available to surgeons social information concerning crippled children.

E. Studies family and environmental conditions of patients to determine whether they are conducive to continue wellbeing of patient after discharge.

F. Cooperates with convalescent and child-placing agencies in arranging post hospital care for patients whose home conditions are not satisfactory, or where the medical program cannot be carried out because of distance from medical facilities.

G. Carries on interviews and home visits.

H. Substitutes for medical social consultant when necessary because of absence of regular consultant.

I. Attends and participates in professional meetings.

J. Assists in contributing medical social knowledge to lay, nursing, and welfare groups.[1]

Rheumatic fever has been a reportable disease in South Carolina since October, 1944. From then until April, 1948, 1,729 cases were reported to the State Board of Health.[2]

In April, 1948, there were 576 cases registered on the

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[1] Ibid., p. 37.

[2] Letter from Miss Lucia Murchison (Medical Social Consultant, South Carolina State Board of Health, Division of Crippled Children, May 3, 1949).

> Rheumatic Fever program and receiving clinic, hospital, convalescent, and foster home care under the Division of Crippled Children. Since April, 1948, we have had approximately 150 cases registered on the program.[1]

Through a telephone conversation on May 6, 1949, with Mr. Charles Mitchell, who is on the staff of the Crippled Children's Bureau, Atlanta Regional Office, we learned that South Carolina spends fifty thousand dollars annually for their rheumatic fever program.

In an article that was written in 1946 about the rheumatic fever program in South Carolina, it was interesting to note that a teacher had been provided by the city school system of Charleston for Negro patients who were confined to their homes because of this disease. At that time, no teacher had been provided for white pupils, and it was recognized as a great need and as a goal for future planning.[2]

The Rheumatic Fever Program works closely with the Division of Vocational Rehabilitation in the state. Patients may remain within the program until they are twenty-one, but they are eligible for attention by the adult rehabilitation program after they have passed their sixteenth birthday.[3]

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[1] Ibid.

[2] M. W. Beach, M. W., et. al., "The Rheumatic Fever Program in South Carolina," Journal of the South Carolina Medical Association, XLII, No. 6, p. 2.

[3] Manual, op. cit., p. 29.

CHAPTER V

THE CARE OF CHILDREN WITH RHEUMATIC FEVER IN THE STATES OF MICHIGAN AND CALIFORNIA

Michigan

In Michigan, the program for the care of children with rheumatic fever is administered by the Crippled Childrens Commission.[1] Physicians estimate that at least fifty children have rheumatic fever in Michigan every year. There are nine diagnostic centers for rheumatic fever in Michigan, and outside Detroit, which has fifteen centers for this purpose. They are found in: Ann Arbor, Kalamazoo, Grand Rapids, Jackson, Lansing, Marquette, Traverse City, Bay City, and Pontiac.[2]

These centers were set up in 1945, jointly by the Rheumatic Fever Control Committee of the Michigan State Medical Society and the Michigan Society for Crippled Children and Disabled Adults. This society made an initial grant of fifteen thousand dollars to help pay organizational and operating costs. This sum is given every year.[3]

Some of the services available to these patients are:

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[1]Federal Security Agency, Social Security Administration, United States Children's Bureau, State Programs for Care of Children with Rheumatic Fever Under the Social Security Act Title V, Part 2, 1944, p. 9.

[2]Michigan Society for Crippled Children and Disabled Adults, "Your Child is Safer in Michigan," [n. d.], p. 1.

[3]Ibid., p. 4.

medical care under a recognized pediatrician, whether the patient is in a hospital, a clinic, a foster or a convalescent home; medical social service for the child and/or his parents to help with problems that have either been aggravated or created by this illness; and nursing services. Usually there is a nurse consultant who is responsible for the district nurses throughout the state. Such nurses in most cases have specialized training in the care of children who have rheumatic fever.[1]

The Michigan program for rheumatic fever is carried on in seven counties.[2] It is interesting to note that of the sixty-five crippling conditions cared for under the Michigan Crippled Children's program rheumatic fever and rheumatic heart disease are ranked sixty-fourth and sixty-fifth respectively in order of frequency of incidence.[3]

California

The rheumatic fever program in California; as in many other states, is not state-wide. For the purpose of this study, two ways in which this state is meeting the needs of its rheumatic fever patients will be cited. One is a demonstration program conducted in a county in California, the other is a group work project in Marin County, California.

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[1] Ibid., p. 3.

[2] A. T. Wilson (Statistician), Quadrennial Statistical Report of Services to Crippled and Afflicted Children, Michigan Crippled Children Commission, July 1, 1943-June 30, 1947, p.1.

[3] Ibid., p. 9.

The setting for the demonstration program is San Bernardino County, California, some fifty miles in from the sea coast. One factor that probably helped make the citizens of this area exceptionally rheumatic fever conscious was their having close contact with the patients of the Rheumatic Fever Unit of the Corona Naval Hospital.[1]

Before the community program was initiated, the following objectives were formulated:

1. To enlist the active cooperation of organized medicine.
2. To enlist the interest and aid of the local school officials, public health officers, public health nurses, school physicians, school nurses, the local hospital administration and civic groups as the P. T. A. and Junior League.
3. To establish a method for case finding.
4. Diagnostic Rheumatic Fever Clinic to be made available without charge to all.
5. Follow-up service organized.
6. Social service objectives to be determined.
7. Institutional care to be provided.
8. Educational and occupational guidance facilities to be made available.[2]

All the reputable physicians in the county were members of the hospital staff, and the schools and the public health agencies participated in case finding. All school children between the ages of six and twelve were examined.

The hospital administration provided the space and equipment for the clinic; and the nurses' organization supplied

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[1]George C. Griffith, M. D., "A Community Program for the Control of Rheumatic Fever," American Journal of Public Health, XXXIX:1 (January, 1949), p. 63.

[2]Ibid.

nursing services. Complete records were kept of the results of the diagnostic tests given rheumatic fever patients on their first visit. These included: a careful medical history, complete physical examination, full blood count, urinalysis and sedimentation rate, electrocardiogram, and fluoroscopic study.

The chief of the clinic, along with his staff, conferred on the diagnosis of each patient. After a diagnosis had been arrived at, a letter was sent to the referring agency. A copy of this letter was filed in the patient's record folder, and another copy became a part of the hospital's permanent record. All patients were admitted and studied without social service investigation as to ability to pay. No member of the staff charged for his services. The cost for the clinic study was sixteen dollars per patient. This was met by the Community Hospital; the Junior League met the expenses of the second year of the clinic.[1]

Each individual diagnosed by the clinic was instructed to return for follow-up consultation regularly. The public health nurses visited the homes of all the patients. Care was exercised to prevent the possibility of upper respiratory infections and the return of rheumatic activity. It is of medical significance that the needs of rheumatic fever patients can best be served if they can spend some time in a convalescent

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[1] Ibid., p. 64.

home. However, this service was, and still is, not available at this time to any great extent. Convalescent home care is preferable for the following reasons:

1. It would be easier to control infections.
2. More attention could be given to the psychological needs of the youngster.
3. Educational facilities could be better utilized if all of the children were in a centralized place.[1]

Group Work Project with Mothers of Rheumatic Fever Patients

Since some time in 1947, the Mother's Club of Marin County, California have been concentrating on help for the rheumatic fever patient.

They decided that the first important thing was to acquaint themselves with the number of children in their counties who were the victims of this disease. They made telephone calls to parents, ran notices in the newspapers, and solicited the help of the school nurses and doctors. The public health nurse was also helpful in this endeavor.[2]

They next talked with the mothers of these patients and interested them in forming a club through which they themselves could learn more about the illness and some of the things they could do to lessen the strains of a convalescent period. The mutual exchange of ideas and experiences was beneficial to these

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[1] Ibid., p. 64.

[2] Ruth Lakeman, "Mother's Club Carries out Project for Children with Rheumatic Fever," The Child, XIII (July, 1948), p. 7.

parents. They were also able to discover some of the needs of this group. For example, one of the mothers needed more training to adequately fullfill her role of nurse and mother.

The American Red Cross was requested to make their home nursing course available to these mothers. This was done, and classes were conducted at night, so that more persons could take advantage of the opportunity. Through this course, the mothers were able to learn, among other things, the ways in which they could adjust the bed to both day-time and night-time conditions.[1]

Through the Red Cross, the mothers were also able to learn some of the simple arts and craft skills with which they could keep their children interested and occupied.

By being in a group with similar problems, the mothers found it was not so difficult to admit that they often felt tired and overworked by the added responsibilities which rheumatic fever infection of their children, had forced upon them. Here the Red Cross was again helpful. They trained a group of college students to serve as substitute parents on occasion, in order to give the real parents a rest. These young women played quiet games, read or told stories to the youngsters, and otherwise entertained them during their mothers' period of rest. These "substitute mothers" were cognizant of the dangers of rheumatic fever and had a working knowledge of the illness.

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[1] Ibid., p. 7.

Therefore, they were able to know what types of activities could be engaged in without damage to the patient. These visits had the approval of the physicians in charge of the patients, and it was under the doctor's recommendations that they worked.[1]

The Mother's Club planned to conduct a general education program for the enlightenment of the public concerning rheumatic fever. By this method of approach, more people would become interested and have a working knowledge of rheumatic fever and, thus, would lend their aid and assistance for more and better care, research, and the training of personnel to serve these patients.[2]

In a demonstration program such as this, or in a program which has been in operation for a much longer period, a medical social worker could make a significant contribution. Because of the social and emotional components, nearly always present in cases of rheumatic infection, and the role played by parental and family attitudes, medical social service is a necessary part of treatment.

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[1] Ibid., p. 7.

[2] Ibid.

CHAPTER VI

SUMMARY AND CONCLUSIONS

This thesis has been a study of the services for children with rheumatic fever and rheumatic heart disease, as offered by four state programs, with emphasis on the role of the social worker. These states (New York, California, Michigan, and South Carolina) represented four sections of the United States (East, West, Middle West and South). The medical, emotional, and social factors involved in rheumatic fever were considered in relation to the total treatment of this illness.

The etiology of rheumatic fever is unknown; therefore, no means of prevention or immunization has been discovered. This is the chief reason why it has been difficult to control this disease. The best treatment method so far devised is one of long-term rest in bed. The very nature of the treatment may tend to create or aggravate social and emotional problems for the child and his family. By working intensively with these individuals, the medical social worker is able to help in the solution of such problems, thereby enabling the patient to receive maximum benefit from treatment; often, her help is in the area of parental attitudes and what the disease means to the child and to his parents and siblings.

In California, New York, and South Carolina, the State Board of Health was responsible for the administration of the programs. In Michigan, the Crippled Childrens Commission

administered these services. Rheumatic fever is a reportable disease in all of the states studied. In California, New York, and Michigan, any child with rheumatic fever who came to the attention of the agency was eligible for treatment. However, in South Carolina, only those who were indigent or medically needy were served, unless diagnostic services could not be secured elsewhere. Those who could pay for medical care were noted only to the extent that they were formally recorded as rheumatic patients.

South Carolina was the only state in which there was statewide coverage. Yet, rheumatic fever is not as prevalent in the South as in the North Atlantic area. In this state (South Carolina), the medical consultant serves in two capacities: that of medical social consultant and as a medical social worker. Usually, the medical social consultant does not give direct service, but she may do so on occasion if such is specifically indicated.

South Carolina has provided equal facilities for white and Negro patients and has one service for Negro children which is not yet provided for white children, namely, tutoring service for school children who have long periods of convalescence. The program for this state ceases to care for persons when they reach twenty one years of age.

The rehabilitation program works with these patients who can benefit from their services, that is, those who will be capable of employment after training. The rheumatic fever

patient in South Carolina is eligible to use the services of the adult vocational rehabilitation division after he becomes sixteen years of age.

The outstanding characteristic of the New York program was the manner in which they incorporated the skills of allied professional fields. They used both public and private agencies to insure the care of their patients. Not only this, but they used what they called supporting services, in which emphasis was given to preventive measures. Information was disseminated regarding rheumatic fever to both lay and professional groups. Educational measures were sponsored for the training of professional personnel who would be involved in the treatment of the disease.

In Michigan, the initiative to start the clinics was taken by the Michigan State Medical Society and the Michigan Society for Crippled Children and Disabled Adults. The latter named society contributed funds for organizational and operating costs when the program originated. They have continued to contribute to the upkeep of the program. This program was carried on in seven counties boasting nine diagnostic clinics outside Detroit. It is understandable why this disease has received little attention in the state of Michigan, when sixty-five crippling conditions cared for under this commission were ranked according to prevalence, rheumatic fever and rheumatic heart disease rated sixty-fourth and sixty-fifth, respectively.

In California, where there is not yet complete coverage,

there was a demonstration program in San Bernardino County, California, where a plan was evolved so that its rheumatic fever patients could receive care. All of the services of the staff were donated, and the clinic was free to all who came. The sixteen dollar cost per patient was met by the Community Hospital one year and by the Junior League the next. In this program, there was coordination of and full participation by all community resources.

A striking illustration of group work with mothers of rheumatic fever patients was given. This project was in Marin County, California, where the mothers of these children formed a club to learn more about the disease and to share their observations and ideas. A cooperating agency, the American Red Cross, worked out a plan that made it possible for the mothers to be relieved of their responsibilities for a short while, with the assurance that their youngsters would be adequately cared for by trained parent substitutes. The American Red Cross offered two other services to this group. One was a course in home nursing to better fit them for the job of nurse and mother; and the other was a course in arts and crafts, to enable them to keep their youngsters occupied and interested.

It is apparent that no program for the care and treatment of rheumatic fever patients could be adequate without the contribution which a medical social worker can offer. Treatment considerations involve the well-being of the "whole child." Not only should emphasis be placed upon the medical aspects of

rheumatic fever, but attention should be given to the common human needs of these children. Each must be individualized and helped to avoid the emotional dangers of "invalidism," and each must be encouraged not to feel that he is "different." How the child responds to treatment may depend in large measure upon the attitude of those in his immediate environment. Parent-child relationships are exceedingly important, and help is often needed in this area.

Because of her special training, the medical social worker is particularly equipped to deal with many of the problems growing out of this illness. Often, economic, social, or emotional factors have as much bearing on this type of illness as the physical factors. Certainly, treatment should be given in all areas if the child is to be helped to a complete recovery and a normal and satisfactory life.

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